Summary of a Typical PACE Model
(Summary by Brenda Schmitthenner)

The PACE model is being used at demonstration sites across the United States. It is not a new model, but one that has proven its success. The PACE model is a total system of care, directly providing a comprehensive package of acute and LTC services on a fully integrated basis. It has been designed to address the complex medical and social needs of the frail elderly, allowing them to live successfully in the community. PACE differs from managed care providers and long term care providers because it enrolls only the very frail, "high-risk" population of the elderly. All enrollees must meet the financial eligibility criteria, as well as the physical criteria for SNF placement. The primary objective of PACE is to maximize the function and independence of enrollees in order to delay or prevent SNF placement.

PACE provides the majority of services, including medical care, adult day care, home care, rehab therapies, personal care, transportation, prescription drugs and meals to enrollees in the community and in SNFs without any limit on dollars or duration of service.

The PACE program fully integrates the delivery of acute and LTC services through interdisciplinary teams which include: physicians, nurses, social workers, rehab therapists, recreation therapists, dietitians and home care workers. This integration is achieved by daily, face-to-face interaction between enrollees and the professionals and paraprofessionals that provide care.

PACE programs receive capitated payments from Medicare, Medicaid, and in some states, private pay sources. This means of payment allows for flexibility in

developing treatment plans and responding to enrollees' needs rather than reimbursement regulations. PACE programs assume total financial risk and responsibility for all medical and LTC without limitation.

The success of this program is found in the case management system. The same people who deliver care meet together on a regular basis to discuss and develop an overall assessment and treatment plan for each enrollee. This approach allows health professionals to respond immediately to changes in the enrollee's condition, which are frequent and often sudden and are most always serious in the frail elderly.

Enrollees attend the PACE Center two to three times a week. There, they receive primary medical care, nursing and social services, rehab and restorative therapies, personal care, and an opportunity to participate in a variety of activities. Enrollees see their doctor on an average of two times a month. When enrollees don't come to the Center, services are provided to them in their homes. When enrollees require a hospital or SNF stay, their care remains in PACE and care continues to be coordinated and monitored by PACE staff, thus assuring continuity of care between services provided in the Center, at home and in institutions.

The quality of care provided by PACE is high and is never sacrificed in pursuit of lower costs. Hospitalization utilization rates for PACE enrollees are at or below levels for the general older population, and SNF rates are way below levels for a comparably frail group. Medicare and Medicaid save between 5% and 15% relative to expenditures for a comparably frail population in the traditional Medicare and Medicaid systems.

There have been some drawbacks noted, however, with regard to the PACE model. Census growth for all PACE sites is a challenge usually due to the requirement

that individuals seeking services must give up their primary care physician to enroll in the program. Another obstacle is that the financial eligibility for this program is very strict and many seniors have higher income or are “over property” to qualify for PACE. Issues affecting the continued success of the PACE model include the ever-increasing shortage of HHAs to provide the supportive services necessary to keep older adults in their homes and the lack of affordable housing for seniors.

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